Iowa Physical Therapy, P.C.

MEDICAL HISTORY QUESTIONNAIRE

Patient Name		Birth Date		Age	
Reason for Therapy			Date of Injury		

Is the Reason for Therapy Accident Related? ☐ Yes ☐ No
If yes, please check one: ☐ Accident ☐ Auto ☐ Work ☐ Other If other, please explain:

Are you currently receiving any other care for the condition mentioned above? ☐ Yes ☐ No
If yes, please explain:

Have you ever received therapy **in the past** for the condition mentioned above? ☐ Yes ☐ No — If so, when?

Previous Treatment Received:		Previous Treatment: ☐ Successful ☐ Unsuccessful

Have you received therapy services for other problems/conditions during this calendar year? ☐ No ☐ Yes
If yes, please list:

Could you be or are you pregnant? ☐ Yes ☐ No

Do you now have any or have you ever had any of the following conditions?

	Yes	No		Yes	No		Yes	No
Arthritis	☐	☐	Diabetes	☐	☐	Numbness / Tingling	☐	☐
Osteoporosis	☐	☐	Anemia	☐	☐	Thyroid Problems	☐	☐
High Blood Pressure	☐	☐	Swelling in Ankles	☐	☐	Headaches	☐	☐
Heart Disease / Attack	☐	☐	Deep Vein Thrombosis (DVT)	☐	☐	Head Injury / Concussion	☐	☐
Pace Maker	☐	☐	Seizures / Epilepsy	☐	☐	Hernia	☐	☐
Stroke	☐	☐	Fatigue / Weakness	☐	☐	Kidney / Bladder Problems	☐	☐
Vascular Disease	☐	☐	Cancer / Tumor	☐	☐	Previous Fracture	☐	☐
Hypersensitivity to Heat/Cold	☐	☐	Recent Weight Loss / Gain	☐	☐	Previous Surgeries	☐	☐
Asthma	☐	☐	HIV / AIDS	☐	☐	Metal in Body or Surgical Implant	☐	☐
Shortness of Breath	☐	☐	Hepatitis	☐	☐	Depression	☐	☐
Chronic Cough	☐	☐	Tuberculosis	☐	☐	Anxiety	☐	☐
Dizziness/Light Headedness	☐	☐	Recurrent Infection(s) or Infection in past 3 mos	☐	☐	Smoking	☐	☐
Nausea / Vomiting	☐	☐	Fever / Chills	☐	☐	Other (please describe below)	☐	☐

If you answered "yes" on any of the above or have other conditions not listed, please explain and give approximate date(s):

Do you have any allergies? ☐ No ☐ Yes, list allergies:

Are you presently taking any medications? ☐ No ☐ Yes, list medications and specify condition:

At the present time would you say that your health is (circle one): Excellent Very Good Fair Poor

This information is correct to the best of my knowledge.

X	
Patient/Parent/Guardian Signature	Date